U.S. Department of State
Bureau of Human Resources/Office of Retirement

TEMPORARY CONTINUATION OF COVERAGE (TCC) FOR A FORMER SPOUSE UNDER THE FEDERAL EMPLOYEE HEALTH BENEFITS (FEHB) PROGRAM

Your coverage as a family member in the Federal Employees Health Benefits (FEHB) Program, ended when you were divorced or your marriage was annulled, subject to a 31-day temporary extension of coverage (at no cost to you) for conversion to a non-group (private) contract. You also have the right to temporarily continue your FEHB coverage for up to 36 months after your divorce instead of converting to a non-group contract at this time.

You may select any plan (for which you are eligible) to continue your FEHB coverage. If you choose family coverage, your spouse and your children will also be covered. To continue your coverage under the TCC provision, you must pay the full amount of the premium (both the employee and Government shares) plus a 2% administrative charge.

If you elect TCC, your enrollment charges will begin the day after the 31-day period of free coverage ends. You will be billed retroactively to the effective date of the enrollment. Therefore, you should take measures to prepare for potential delays by setting aside funds for the lump sum due for the first payment. If you continue TCC to the end of the 36-month period, you will have another 31-day temporary extension of coverage (at no cost to you) for conversion to a non-group contract.

To elect TCC, you must complete this DS-5068 "Temporary Continuation of Coverage for a Former Spouse" and a new Health Benefits Election Form (SF-2809). HR/RET must receive your SF-2809 within 60 days from the date you were divorced or your marriage was annulled.

You may bring, fax or mail your documents to:

Department of State
Office of Retirement (HR/RET)
Attn.: TCC Coordinator
Room H-620, SA-1
2401 E Street, N.W.
Washington, D.C. 20522-0108

TEL #: 202-261-8960
FAX #: 202-261-8988

The current Guide to Federal Employees Health Benefits Plans for TCC and Former Spouse Enrollees (RI 70-5) outlines the plans, rates, payment liability, and other factors regarding the FEHB TCC Program.

It may take one to two months before you hear from the National Finance Center (NFC) Billing Unit. You may use your copy of the Health Benefits Election Form (SF-2809) that has been certified by this office to obtain medical services until you receive your ID from the carrier. The NFC sends a Notice of Enrollment letter and coupons to new enrollees on the first of the month after the SF-2809 is processed or after the effective date of coverage, whichever is later.

TCC cancellations are effective on the last day of the month, not the end of a two-week pay period. If a request is received more than fifteen days before the end of the month, the cancellation becomes effective at the end of that same month. Termination of coverage because of nonpayment is considered a voluntary cancellation. Once the cancellation takes effect, you will not be entitled to a 31-day extension of coverage for conversion to a non-group policy.

The NFC DPRS Billing Unit may be reached on 1-800-242-9630.
The line is available 7:45 a.m. to 4:00 p.m. Central Time, Monday through Friday.

The NFC address is:

National Finance Center
DPRS Billing Unit
P. O. Box 61760
New Orleans, LA 70161-1760

For additional information, please visit our Web-site : http://www.RNet.state.gov/

If you don't find your answer there, send an e-mail to RETServices@state.gov

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TEMPORARY CONTINUATION OF COVERAGE (TCC)
FORMER SPOUSE REPORT OF ELIGIBILITY FOR FEHB

This form must be received within 60 days of the Former Spouse's loss of regular FEHB coverage as a dependent.

Full Name Of Former Spouse *(Last, First, Middle)*	
Former Spouse's Birth Date *(mm-dd-yyyy)*	Former Spouse's Social Security Number *(123-45-6789)*
Full Name And Birth Date Of Dependent Children. *(Attach An Additional Sheet , If Applicable)*	Date *(mm-dd-yyyy)*
Former Spouse's Address *(Apartment Number, Street)*	
Address *(City, State, ZIP Code)*	Personal E-Mail Address *(JohnDoe@provider.com)*
Telephone Number	FAX Number
Date Of Loss Of Regular FEHB Coverage *(mm-dd-yyyy)*	

Reason for Loss *(Please Check One):*

- ☐ Divorce Please Provide A Copy Of The Divorce Decree.
- ☐ Loss Of coverage Under The Former Spouse Equity Act.
- ☐ Other *(explain)* _____

AGENCY EMPLOYEE INFORMATION

Full Name Of Employee or Annuitant *(Last, First, Middle)*	
Birth Date *(mm-dd-yyyy)*	Social Security Number *(123-45-6789)*
Former Spouse's Signature	Date *(mm-dd-yyyy)*

SUBMIT FORM TO:
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Office of Retirement HR/RET
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2401 E Street North West
Washington, DC 20522-0108

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FAX (202) 261-8988